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NATIONAL HOSPITAL
PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT
FRESNO, CALIFORNIA

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TABLE OF CONTENTS

		Page
1.0	**OVERVIEW OF FRESNO, CALIFORNIA**	1
2.0	**SCOPE OF INTERVIEWS**	3
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	5
	3.1 Competitive Market Structure	5
	3.2 Hospital Performance	7
	3.3 Competitive Processes	8
	3.3.1 Price Competition	8
	3.3.2 Cost Competition	10
	3.3.3 Non-price Competition	12
	3.4 DRG Monitoring	14
	3.5 CEO/CFO Reactions to PPS	15
4.0	**PPS AND ALTERNATIVE HEALTH PLANS**	18
	4.1 Structure of the Local Industry	18
	4.2 HMO Competition	19
	4.3 HMO's, PPS, and Hospital Contracting	19
	4.4 HMOs and PPS Impacts on Their Cost Advantage	20
	4.5 Contracting with Physicians	21
	4.6 Utilization Review	21
	4.7 Medicare Enrollment and Contracting	21
5.0	**MEDICAL PRACTICE PATTERNS UNDER PPS**	23
	5.1 Site Background	23
	5.2 Overall Assessment	23
	5.3 Lengths-of-Stay Monitoring	24
	5.4 Admission Controls	24
	5.5 Specialization	25
	5.6 Outcomes	25
	5.7 Physician Reactions to PPS	26
6.0	**THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS**	28
	6.1 Industry Structure	28
	6.2 Hospital Admissions and Discharges	29
	6.3 Hospital Discharge Planning	30
	6.4 Home Health Agencies	32
	6.4.1 Adaptions	33
	6.4.2 Patient Care Problems	33
	6.4.3 Administrative Problems	34
	6.5 Nursing Homes	35

TABLE OF CONTENTS (Continued)

		PAGE
7.0	**PROGRAM OPERATIONS**	36
	7.1 Peer Review Organization	
	7.1.1 Administration and Organization	36
	7.1.2 Functions	36
	7.1.3 Relations with Government and Providers	37
	7.1.4 Review Process	37
	7.2 Fiscal Intermediary	39
	7.2.1 Administration	39
	7.2.2 PIP and CPEP	40
	7.2.3 Activities	40
	7.2.4 Relations with HCFA	42
	7.2.5 Beneficiary Problems	43

PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF FRESNO, CALIFORNIA

The Fresno MSA lies entirely within Fresno county in central California. The county stretches from the coastal mountains near the Pacific Ocean to Yosemite in the high Sierras, covering on area three-quarters the size of Massachusetts. The city of Fresno has roughly 600,000 people and is growing 6-8 percent annually, providing a strong impetus to hospital demand. Eleven short-term general hospitals operate in the county. Most are in the city of Fresno or in adjoining small towns within 45 minutes of each other along Highway 99 connecting Los Angeles and San Francisco. Even though several are in quite small rural towns, all are considered urban for PPS reimbursement. While Fresno would generally not be considered an overbedded area, having only 3.1 acute beds per 1,000 population, occupancy rates vary considerably between rapidly growing Fresno and the outlying agricultural areas.

Besides the eleven acute hospitals, there are 77 licensed nursing homes in the region, 57 of which are Medicare-certified, skilled nursing facilities. Of the 28 home health agencies, only five are Medicare-certified. Finally, compared to other parts of California, Fresno county has relatively fewer physicians, although the per capita rate is not particularly low (i.e., 1.8 per 1,000 population).

The overall hospital market structure is bifurcated, with three large urban hospitals competing largely with each other while small outlying hospitals compete primarily with the large tertiary hospitals in Fresno and less with each other. High occupancy rates, coupled with an expanding population, minimizes the observed competition among the "big three" in Fresno, particularly regarding charges. Non-price competition is especially active in providing outpatient services and promotion, but not so much with respect to adding new services.

Pre-PPS mergers had strengthened some groups, and most seem to have benefited financially under the program, but for different reasons. Urban hospitals have experienced large increases in their Medicare casemix indices. One also has received a large indirect medical education payment supplemented by a sizeable disproportionate share payment as well. "Rural" hospitals outside Fresno are financially stable despite occupancy rates below 40 percent in part because they are receiving the Medicare urban rate for the Pacific region.

Hospital use patterns have always been conservative in Fresno. Medicare lengths of stay are among the shortest in the country. Physicians and hospitals have also been in the vanguard in the shift to outpatient surgery. Conservative use patterns have placed Fresno hospitals in an advantageous position as PPS moves to national rates. They have also discouraged HMO activity in the past. The greater Fresno area was one of the last metropolitan areas in California to adopt HMOs, in part due to a close-knit medical community. The area now has at least eight plans. None, however, has Medicare at-risk contracts because the area's AAPCC is the lowest in California; nor do any have a sizeable enough share of the market to negotiate significant hospital discounts or shift the risk of overutilization to institutions. Finally, because physicians were already using acute facilities in a conservative manner,

PPS has had little additional effect on their practice patterns. Corroborating this finding is the lack of stringent DRG case monitoring in most hospitals.

Practice patterns have been most affected on the outpatient side, particularly for home care. California has had a very large nursing home industry, but Medicare patients are a miniscule part of its caseload because of limited coverage. High demand for nursing home beds gives providers the leverage to selectively avoid sicker patients that either must remain hospitalized or treated at home.

PPS has significantly enhanced the role of discharge planners who are now using home care as never before. Most urban hospitals have their own home health agency to facilitate early discharges which have grown rapidly--particularly for "high-tech" care. Agency staff report some "premature" discharges resulting in readmission, but the more serious placement problem is a lack or funding for the non-skilled services required in the home after hospitalization.

2.0 SCOPE OF INTERVIEWS

The Fresno area site visit was conducted with a series of interviews both inside and outside hospitals. Six hospitals participated: four in the city of Fresno itself and two others in small adjoining towns. The four Fresno hospitals were between 250 and 450 beds while the two outlying hospitals were 35-70 beds. Only one hospital had a teaching affiliation. It was the county hospital as well.

A total of 45 people were interviewed over a five day period (see Table 1). Five chief executive officers, five chief financial officers, and two vice-presidents of operations were questioned in the areas of competition and hospital management. Five discharge planners were questioned about the aftercare industry. The areas of inpatient utilization and patient management were discussed with four medical directors, two chiefs of staff, five U/R coordinators, and two DRG coordinators. Outside the hospital, five additional physicians were interviewed in the utilization/patient management area. Two were family practitioners, two were orthopedists, and one was a cardiologist. All five were admitting physicians in at least one of the six hospitals. Outside the hospitals, interviews were conducted at two of the larger HMOs.

Interviews covering Medicare program operations area conducted at the Fiscal Intermediary (FI) in Los Angeles and the Peer Review Organization (PRO) for northern California. One day each was spent interviewing the director and staff at the PRO and the FI.

Interviews were conducted with the aftercare industry both inside and outside hospitals. In addition to the five discharge planners interviewed, six outside interviews were conducted with three nursing home administrators and three home health agency administrators.

TABLE 1

FRESNO, CALIFORNIA SITE VISIT INTERVIEWS BY TOPIC AREA

	Hospital Competition	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	5			
CFOs/Controller	5			
V.P. of Operations	2			
U/R Coordinator		5		
DRG Coordinator		2		
Medical Director		4		
Chief of Staff		2		
Family Practitioners		2		
Cardiologists		1		
Orthopedists		2		
Discharge Planners			5	
California PRO				1
Fiscal Intermediary				1
Nursing Home Administrators			3	
Home Health Agency Administrators			3	
HMO Directors	2			
Total Number of Interviews	14	18	11	2

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Market Structure

Although all of Fresno county is considered a single urban MSA for PPS reimbursement, multiple markets exist within its borders, each with a loose connection to the greater Fresno City market area. The many small towns along the major north-south highway have their own hospitals delivering mostly primary acute care and transferring more serious cases to the larger Fresno hospitals. As most hospitals are near the interstate highway along perfectly flat farmland, it takes less than an hour for patients to reach Fresno proper for tertiary care.* The proximity of outlying hospitals to the Fresno market forces them to concentrate more on primary acute care than elsewhere in the United States.

The city of Fresno has five non-profit hospitals (counting the facility in nearby Clovis), but three are organized into a single financial entity called the Community Hospitals of Central California (CHCC) with 650 total beds (one 450 and two 100 bed institutions). This leaves the "big three" major urban competitors, CHCC's three institutions, a 350 bed Catholic hospital, and the 450 bed county teaching hospital. The three together form an oligopolistic market structure of large, well-established providers. Each rival is sensitive to the pricing and service policies of the others, particularly the two non-government competitors.

Fresno County is the second fastest growing area in California. Population increased 7.5 percent in 1985 alone. Effective competition among the three is significantly attenuated by this fact. Occupancy rates are above 70 percent with the exception of a couple of hospitals that are part of CHCC. Population growth is primarily outside the downtown area, however, favoring some hospitals and encouraging new hospital construction or mergers by other competitors. Population growth has been generally confined to the Fresno city limits, leaving the other hospitals in satellite towns vulnerable to the large decline in utilization found everywhere in the early 1980s.

All hospitals in the MSA are non-profit. One is a county hospital, several others are district hospitals that enjoy local tax subsidies, and one is a member of a system of 14 Catholic hospitals located throughout the United States.

No single hospital or consortium is a clear, dominant leader, as is often the case in smaller cities with a significant teaching hospital. In Fresno, the only teaching hospital is also the original county hospital founded in 1897 in the older, poorer section of town. While it is also the major trauma center, it is not an aggressive competitor, burdened in part by a very high bad debt percentage. The Catholic hospital and the CHCC consortium remain the two principal rivals in terms of pricing and services.

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*The one exception is the 25-bed Coalinga District Hospital about 60 miles southwest of Fresno.

The Fresno city hospitals as a group represent strong leadership in price, services, and reputation vis-a-vis outlying hospitals. Like many rural hospitals operating on the fringes of large metropolitan cities, quasi-rural outliers must constantly protect their small markets from the marketing, physician recruiting, service expansion, and other competitive activities of the "big three" urban providers, even when such actions are not directed at them but each other.

In spite of being in a rapidly growing area with in-migration of younger families, Medicare payments still average 45-50 percent of the typical hospital's revenues, with the county teaching hospital being the notable exception at 20 percent. Major teaching hospitals are generally less Medicare-dependent, which in this case is reinforced by the California requirement that all indigents use the county hospital system. California State Medicaid, called MediCal, is also a larger percentage of hospital revenues (15-20 percent) than elsewhere, with the exception of one facility which is operating in the more affluent section of Fresno. Commercial insurance averages 20-30 percent, including a significant percentage of HMO-PPO revenues in a few hospitals. Blue Cross is typically less than 5 percent, which is only a fraction of what its share is elsewhere.

Blue Cross pays on discounted charges on both its regular business and its PPO. MediCal's Selective Contracting is totally unique, with nearly all hospitals being paid a negotiated, all-inclusive per diem rate that has not been updated since 1982. Thus, at least two-thirds of the typical hospital's revenue is on a fixed, all-inclusive per discharge (Medicare) or per diem (MediCal) rate while the rest either pay discounted charges or nothing at all. Essentially no revenue comes from cost-based payers.

Six or seven HMOs are active in the Fresno area, but only one has been active for several years. HMO penetration is less than 10 percent but growing. Most pay discounted charges although a few have per diem rates with the hospital. PPOs are also popular in California, but the total HMO-PPO share of revenues in Fresno is still quite minor. A highly fractionated HMO market results in active competition for subscribers and providers, but because none commands a significant enrollee base, discounting is minimal and they, rather than the hospitals, bear almost all of the cost and utilization risk.

All of the hospitals in Fresno County receive the PPS urban rate; this in spite of the fact that several are small (less than 60 beds), primary acute care hospitals in towns of less than 25,000 people. Consequently, they receive the same Federal PPS payment as the large Fresno hospitals even though their base year, hospital-specific costs are only half to two-thirds as much. Such a large discrepancy in relative costs and payments between the Fresno city and outlying hospitals affords the latter considerable financial protection against the heightened competition for patients with the "big three" Fresno providers.

Only the county teaching hospital receives any additional payment for Indirect Medical Education (IME), but it is a substantial (20-25 percent) add-on to the basic Medicare DRG payment. The county and one other urban hospital also began to receive the maximum 15 percent add-on

for Disproportionate Share Hospitals (DSH) in the fall of 1986. None of the hospitals receives a significant percentage of their Medicare revenues through outliers, which is attributable to the very short stays in the area.

DRG casemix complexity in the "big three" Fresno hospitals rose 15-20 percent from 1981-85, even with above-average index values to begin with. Casemix complexity in rural hospitals grew only a third as fast due to their concentration on primary acute care and fewer complicated DRGs.

Thus, in terms of Medicare payments, the large Fresno hospitals materially supplemented their basic DRG rates either through IME and DSH add-ons of 15 to 30 percent, DRG upcoding of 15-20 percent, or both. Given that most were starting with PPS hospital-specific rates only slightly above Federal rates, these add-ons more than offset any losses via transition. The situation appears nearly as good for the small outlying hospitals, not because of PPS add-ons or DRG upcoding, but because they were eligible for the same urban rate as their large Fresno competitors, a rate 40-75 percent above their own hospital-specific costs.

3.2 Hospital Performance

Because of the rapid, but unevenly distributed, growth in county population, the volume declines evidenced elsewhere in the U.S. have not been uniform across Fresno hospitals, nor have they generally been as large. The "big three" hospitals have had stable or increasing average daily censuses, although one CHCC facility has experienced a 25 percent census decline primarily because of a tripling of outpatient surgery. Occupancy rates ranged between 70-85 percent in 1986. Rural hospitals have been less fortunate, losing 10-25 percent of their patients through competition with Fresno or tighter pre-admissions review. Very short average lengths of stay prior to PPS have limited volume declines to the fall-off in admissions, unlike other parts of the country where declines have been cumulative. For hospitals in growing areas of the city, stable lengths of stay mean rising occupancy rates and a very solid competitive position.

Five of the six hospitals in the site visit reported significant positive operating and total margins. The county teaching hospital was incurring major operating losses (between -5 and -6 percent) that are directly attributable to its 34 percent bad debt rate (of which only about half is covered by California's Medically Indigent program). Medicare discounts on gross charges were less than five percent, counting capital and IME payments, which certainly more than covers incurred costs. Now that the hospital is receiving an additional 15 percent Disproportionate Share payment, this should more than compensate for the final transition to lower Federal rates. The other large Fresno hospitals report total margins of 7-10 percent, with a large jump during the first year of PPS. The jump was the result of a combination of higher Medicare casemix indexes, a series of cost-saving measures, greater utilization, and significant teaching add-ons to the rate. These

margins fell somewhat in the next two years of PPS as the "big three" embarked on a number of expansion and rivalrous activities (described later).

The two "rural" hospitals both show large gains in profit margins post-PPS in spite of occupancy rates hovering around 40 percent. While hospital administrators are critical about many technical details of PPS, one admits that the "hospital couldn't have paid its bills without PPS." This is almost entirely the result of these small, basically rural, institutions enjoying a Medicare urban payment rate nearly double their estimated average costs (after adjusting for the higher than average wage index in Fresno County as well). As another indicator of Medicare's revenue effects, Medicare discounts on charges were immediately halved with the transition to fixed payment rates.

Not all hospitals have thrived under PPS. Two hospitals within the greater Fresno city limits appear to be victims of the heightened competition and the rapid switch to outpatient surgery. But as both now operate under the combined management of CHCC, they enjoy the financial and management support of the group and should survive. Indeed, takeovers of underutilized facilities are often part of a long-run growth strategy of the stronger partners seeking ways to expand capacity into high growth areas of the city.

Rural hospitals in Fresno county would appear to be on shakier ground--particularly if HCFA geographically limited the urban rate to the city of Fresno alone. They are heavily dependent on Medicare and many could not survive what could amount to a 25 percent reduction in Medicare payment (not even counting any corresponding reduction in their wage index).

3.3 Competitive Processes

Hospitals compete in three ways. The first is through lower prices, or at least slower rates of increase, that attract patients. The second is through management improvements that lower costs for a fixed price schedule. Third, hospitals can engage in various forms of nonprice competition. (See Table 2 for a summary of the strategic elements within each competitive domain.)

3.3.1 Price Competition

Very little overt price competition is occurring in Fresno county, although covert competition via discounting is prevalent, if not virulent. While a few hospitals froze their rates early on in PPS, most continue to raise charges 5-10 percent annually in spite of rising profit rates and some drastic falls in admissions. For some, raising charges is a logical necessity due to falling utilization. "We will raise prices until we see that it is clearly depressing volumes," said one CFO. No CFO believes that stated charge increases lie behind declining volumes. Rather it is a combination of growing outpatient surgery, fewer social admissions, and rivalrous non-price competition. Within Fresno, the highly successful Catholic hospital plays the role of price leader with the other two competitors keeping price increases at or below par.

TABLE 2

COMPETITIVE STRATEGIES IN FRESNO, CALIFORNIA

Price Competition	Cost Competition	Non-Price Competition
	Structural	**Services**
• Frozen daily room rates early on in PPS • Frozen MediCal per diem since 1982 • Lower lab/x-ray charges • Lower outpatient surgery charges • All-inclusive outpatient surgery fee • Minor HMO/PPO discounting of charges	• Converting beds to new services (outpatient, surgery, dating disorders) • Taking beds out of service • Expanding SNF care • Closed OR suites • Step-down units for cardiac monitoring	• Emergicenters • Magnetic Resonance Imaging • Home Health Service • High tech outpatient pharmacy • Upgrading trauma facilities • Full-time CAT scan • Wellness, geriatric • Occupational, sports medicine • Ultrasound, gastro-endoscopy in rural hospitals • MRI, CT scan joint ventures with physicians
	Labor	**Specialists**
	• Option of higher salaries with fewer benefits and no guaranteed hours • Introduced labor productivity monitoring systems • Emphasized part-time workers • Frozen/low wage increases • Shifted excess nurses to pharmacy, extended care • Substituting RNs for LPNs • Introduced patient acuity systems for nurse requirements • Introduced merit wage adjustment • Substituted capital for labor in word processing, medical records, CT scans	• Recruiting rheumatologists, diabetologists, psychiatrists • Part-time sharing of orthopedic surgeons and ophthalmologists in rural hospitals
	Non-labor	**Primary Care Networks**
	• VHA group purchasing • Self-insurance for health care and workers compensation • Computerized inventory control, patient accounting and EKG filing • Energy-saving systems • Installed mini-pharmacy in nursing units	• Constructing medical office buildings next to hospital • Establishing own HMO
	Utilization	**Promotion**
	• DRG monitoring of physicians • Diabetologist to shorten stays • Block time in surgery	• Guest relations • Extensive newspaper, TV, billboards, and radio advertising • Valet parking • Special meals for OB patients • Physician referral • Community surveys • Upgrading facility's appearance
	Organizational	
	• Merger of three hospitals in 1983 to spread overhead costs. • Hospital management agreements between rural and urban hospitals to upgrade rural capabilities	

Mentioned more often than rival hospitals as a deterrent to price increases, however, are the independent labs, radiologists, and surgicenters.* As elsewhere, declining admissions have left hospitals with unused ancillary capacity coincident with a rapid expansion in outpatient testing facilities. "Our hospital," says one administrator, "no longer raises charges across the board anymore, but [must] selectively adjust them to the competition, demand, and insurance coverage."

A relatively small percentage of hospital revenues are based on charges in any event. Medicare comprises 40-50 percent of revenues, MediCal another 15-20 percent. Both pay on a fixed per discharge or per diem independent of charges. MediCal has not updated its rates in four years, which has produced implicit 50 percent discounts. Yet, no hospital is willing to forgo such a large volume, nor have any had to, given profits generated on Medicare patients.

De facto price competition comes not so much in setting charges as in discounting them among the numerous insurers and HMOs. All hospitals grant minor (less than 10 percent) discounts with the many HMOs, PPOs, unions, and employer groups in central California. Because HMOs are relatively new, extremely competitive for subscribers, and small relative to the total market, none can command significant discounts. Hospitals still have been willing to negotiate minor discounts with all HMOs and PPOs under the threat of revenue loss to a direct competitor and the adverse effects non-participation might have on each hospital's image. Most contracts are on discounted charges while a few are on per diems that put hospitals at risk for intensity increases, if not longer stays.

In sum, only about one-third of the typical hospital's revenues in Fresno County is even based on charges, and even some of this is in the form of negotiated per diems. Although numerous HMOs and PPOs operate in the area, none is large enough to negotiate significant discounts or shift utilization risk to the hospital. The "big three" recognize the mutually destructive effects of a price war and adhere to oligopolistic price setting with a recognized leader. Finally, outlying hospitals continue to raise charges in spite of declining utilization due to a perceived highly inelastic demand. Higher stated charges also permit additional flexibility when negotiating discounts to numerous, small insurers.

3.3.2 Cost Competition

Fresno hospitals, unlike those elsewhere in the United States, have very short stays (often less then 5 days) and high per diems.**

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*The California legislature recently passed a bill permitting free-standing surgicenters to install three-day beds to accommodate patients needing overnight observation. This makes them even more competitive with hospitals--particularly as they are exempt from various JCAH staffing and other requirements.

**Several administrators cited the earlier MediCal utilization experiment 15 years ago as the impetus to discharging patients sooner.

Consequently, in central California the industry is faced with a cost problem that is not easily solved through shorter stays. Within the county, the "big three" urban competitors are stable or growing, which helps spread their high fixed costs and avoids cost pressures to some degree. Outlying hospitals have experienced utilization declines that have resulted in more cost consciousness, albeit more under the initial uncertainty of PPS than after its implementation and financial windfall. Inequality in performance leads to different containment strategies. Cost management efforts can be categorized into five areas (see Table 2):

(1) Structural;
(2) Labor Costs;
(3) Non-labor costs;
(4) Utilization Controls;
(5) Organizational.

A few hospitals are undertaking structural changes to more effectively use expensive beds and facilities, including converting beds to new outpatient surgery areas, treating eating disorders, step-down units for cardiac telemetric monitoring, or simply expanding SNF care. Bed conversions are less than elsewhere, however, because of rapid population growth and reasonably high occupancy rates (except for outlying hospitals). One or two hospitals have also closed underutilized operating room suites and redesigned the building to conserve on energy costs.

High labor costs have contributed significantly to California's high cost per day, if not per case, and Fresno hospitals have probably done the most in this area to reduce costs. A generally-voiced concern over employing too many expensive professionals has resulted in frozen, or very low, wage increases in several hospitals. On the other hand, after the initial uncertainty of PPS evolved into certain profits, wage increases in a few hospitals more than made up for previous cuts. Many had already introduced labor productivity monitoring systems prior to PPS, but now administrators appear to be vigorously using them to reduce staffs. Practically all are consciously substituting RNs for LPNs through attrition of the latter, taking advantage of the RNs' greater range of skills and relatively low salary, and a couple were emphasizing part-time workers more. Several hospitals also mentioned their recent adoption of nursing acuity systems to better determine nursing needs by unit and skill type. One had introduced a merit wage adjustment for all employees, while another was offering employees the option of reducing their fringe benefits and giving up guaranteed full-time employment in return for higher salaries.

Cutting non-labor costs is also being pursued. Group purchasing through the Voluntary Hospitals of America is popular in Fresno and is also a reason for the CHCC merger. One outlying hospital is also taking indirect advantage of the merger by negotiating a management contract with CHCC to take advantage of the combined purchasing power, reporting systems, and management expertise of the larger system. Hospitals are

also self-insuring for their employees' health care and workers compensation and installing satellite, or mini-pharmacies on the nursing floors to reduce requisition times.

Because of the extremely short Medicare stays, hospitals, while generating DRG reports on patients and physicians, are not aggressively using them to alter physician behavior. (See Section 3.4.) One hospital had been having trouble reducing stays for diabetics and hired a diabetologist. More intensive therapy and patient education resulted in a halving of diabetic lengths of stay. Another hospital, experiencing both underutilization and bottlenecks in the operating room, began to use block scheduling with staff monitoring of the surgeon's use of his/her time allotment.

Finally, about half of the hospitals had undergone some type of financial or administrative reorganization in the last few years. First, and most indicative of the competitive future of the community, three hospitals merged in 1983 to form CHCC. This effected a horizontal integration of three competitors, two of which continue to suffer from underutilization, as well as a vertical integration of several nursing homes, laboratories, and radiological services. Integration encourages earlier discharges without necessarily losing revenues, but more importantly, administrative overhead is reduced and the combined entity can pool financial resources and share services.

Both small, outlying hospitals underwent major changes in administration a year after PPS was implemented as a result of declining use and desultory management. New management has instituted a range of efficiency and service changes, raised prices, brought in part-time surgeons and specialists to reduce patient leakage to Fresno city, and expanded outpatient facilities. Their financial success has been materially enhanced as well by Medicare rates substantially higher than actual costs.

3.3.3 Nonprice Competition

Nonprice competition continues to be the primary way in which hospitals compete for patients. With Medicare now paying only on admission and the influx of many new HMOs, rivals must be far more concerned about securing and maintaining a viable market share. The particular structure and conditions of the market, however, attenuate the rivalry one might expect with so many new HMOs and PPOs. Rapid population growth relieves some of the competitive pressure to entice patients away from other facilities. Moreover, the county teaching hospital simply does not play an aggressive leadership role as one of the "big three" rivals. It already specializes in trauma and burn care and has a fairly high occupancy rate. Finally, the merger of three Fresno hospitals into CHCC restricts patient competition even further.

Because of the reasonably close proximity of several tertiary care centers, few outlying hospitals offer anything more than the basic hospital services. Several do not even have ICUs. This further restricts nonprice service competition outside the Fresno city limits.

Several forms of service competition are flourishing, nonetheless. Most hospital rivals have set up emergi-centers around the city as feeders to the acute care facility and as a supplemental revenue source. Most have their own home health agency to support their very short inpatient stays, and they own either nursing homes or hospices. Outpatient durable medical equipment and high tech pharmacies are very recent enterprises, as are occupational, sports medicine, wellness, and geriatric clinics. One hospital is upgrading its trauma facilities to compete more directly with the county hospital.

One very interesting endeavor is a joint venture between CHCC and the Catholic hospital, the two principal rivals in Fresno, to provide Magnetic Resonance Imaging. A group of radiologists is a third partner. Thus, even with active competition rivals have been able to develop a sharing arrangement (and pool the risk) for a very expensive medical technology.

Outlying hospitals have more separable markets and compete more with Fresno then each other in terms of services. They are expanding outpatient surgical services in an attempt to stem patient migration to Fresno. This is an area where they feel they can compete more actively than they have in the past now that surgeons are more plentiful.

Urban hospitals do not actively compete for specialists; their staffs are already large and diversified. They do recruit some very specialized physicians like diabetologists and rheumatologists from outside the area, but more to streamline patient care and shorten stays than to compete directly for patients.

Rural hospitals, on the other hand, need specialists in order to compete with the tertiary care centers. Through a management contract with CHCC, one hospital was making use of rotating orthopedic surgeons and other specialists several days a week to perform outpatient surgery. Hospitals slow to put such arrangements together have suffered greater patient and revenue losses.

Primary care networks are relevant more to outlying hospitals, although urban facilities have been building clinics as feeders as well. The rural hospitals, however, do not appear very active in developing primary care networks, at least in greater Fresno county.

Probably more important than networks are the HMO and PPO arrangements of the urban competitors. One dissolved its relationship with an established network HMO and started its own HMO with staff physicians and the Harvard Community Health Plan as financial and management partners. Another hospital then signed an exclusive contract with the existing HMO. HMO subscriber competition among hospitals would be even greater if the county teaching hospital was viewed as an active rival, but it does not have any HMO contracts at the present time.

Promotion, the fourth variant of nonprice competition, is certainly the most visible of all the forms of rivalry. CHCC and the Catholic hospital use every type of media: television, radio, newspapers, brochures, and billboards, to project their images. The former emphasizes its broad service mix across several facilities and its community orientation while the latter concentrates on this technological excellence. One hospital was offering valet parking, special meals for

OB patients, and a physician referral service for new residents seeking a primary care physician. All are concerned and have upgraded their facilities to improve their images of progressive solid institutions.

Rural hospitals are not nearly as promotion-oriented; probably because "patients really have no choice--we are the only hospital in town." They also lack the resources to undertake large campaigns outside their immediate vicinity, which would put them directly in competition with the Fresno tertiary facilities in any event.

Several hospitals had conducted patient and community surveys to determine what people liked and disliked about the hospital. Responses indicated a general lack of knowledge about service mix that led to informational advertising campaigns.

3.4 DRG Monitoring

All of the hospitals participating in the case study have developed a DRG reporting system giving frequency of cases by DRG as well as charges, payments, and length of stay by DRG by physician. Most are computerized although one hospital was so small that it produced a top 10 DRG monthly listing by hand. The absence of any patient-specific utilization and cost information prior to PPS led to a scramble for DRG software. CEOs and CFOs did not know their casemix with any certainty, or its variability across time. They did not know who the big physician admitters were, who kept their patients in a long time, or which kinds of patients generated large bills. Certainly, they did not know the true marginal cost of most services--and still don't. DRG-specific payment put a premium on such knowledge for the first time, and administrators have responded quickly.

As elsewhere, CEOs met with physicians as a group at the start of PPS and explained the system, its incentives, and the hospital's financial stake in managing patients well. The area PRO also held meetings with UR staffs to explain their procedures and criteria. But, unlike other areas, DRG payment does not appear to have led to stringent, continual monitoring of patient care for the simple reason that Fresno has one of the shortest average stays in the county (5-7 days, depending on hospital).* Examples of targeted improvements that were cited include studies of open heart surgery, oncology, and diabetes, overuse of the pharmacy, and respiratory therapy, but in the words of one CFO, "educating physicians did not translate into sound operational policies." Others felt DRG evaluation and specialization were inconsistent with the hospital's mission and unnecessary given their staff's conservative use of hospital resources. Several administrators went so far as to form DRG committees to examine patient data, but operational policies rarely materialized as administrators did not want to alienate physicians unnecessarily with bad data. In one instance, the

*One hospital, for example had a Medicare length of stay of 6.6 days with a 1985 Medicare casemix index of 1.35. This was typical of the large tertiary hospitals in Fresno.

physician head of the UR committee flatly refused to counsel his peers on their practice patterns. Besides, administrators do not see themselves as "policemen" but rather "just providing care" under the physician's direction, abdicating management responsibility to peer review and the PRO.

DRG monitoring appears to have declined after 1984 once the profitability of the system became apparent. Such is the natural outcome of truly conservative inpatient use, extensive DRG upcoding, and urban payments to essentially rural hospitals. A few administrators see DRGs more as a mode of product line management of what the hospital does best than as an internal cost control system. Another found them helpful in choosing to drop the exemption on their psychiatric unit for the more profitable DRG payment.

3.5 CEO/CFO Reactions to PPS

Hospital CEOs and CFOs had several positive and negative comments about PPS.

Update Factor

"Too unpredictable; no idea of rates two years in advance."

"DRG rate structure needs adjusting; update squeezing alone won't work."

"No national health care policy. Hospital industry will begin to insist on policy towards minorities, small kids, women, older Americans regarding access."

"If Congress, for example, wants to spend less money saving neonates and more on immunization and welfare, it must set priorities. If it feels the elderly should be allowed to have heart bypasses, then they should pay for it."

DRGs

"DRG price weights not right given low correlation of costs and weights."

"Need to recalibrate DRGs, add new categories, and fine-tune to post-PPS experience."

"PPS doesn't recognize changes in acuity."

"Should prevent DRG upcoding; too much room for manipulation."

"Need to improve DRGs and expand to other payors to reduce cost shifting."

"Oncology seems to be a consistent loser."

Regional/National Rates

"Should continue to use regional rates; national rate doesn't make medical or economic sense. West coast hospitals have most efficient system with highest costs and are most at risk with big losers."

"Shift from state to national rates bad. Capital payment should consider that land and buildings are more costly west of the Rockies."

"System of national comparison rates good in that it provides a focus for economic decisions."

Outliers

"Rural patients seek care later than urban patients, resulting in more outliers."

"Need to group hospitals by volume and set different outlier thresholds due to higher risk."

"There must be a basic fallacy in outlier calculation because it is so inadequate."

"Why not add catastrophic component to outlier payment."

Physicians

"Hospital is not the government's policeman. Just providing care. Let peer review monitor care."

"Unfair for physicians to avoid accepting assignment when hospitals must participate and not balance bill."

"As 55 percent of the internist's income comes from inpatient rounds, I want him under same length of stay incentives."

"Can't fully manage hospital until physicians are under the same system."

"Physicians control services and need to be financially linked to DRGs."

PROs/FIs

"Hospital can't get PRO reports. A lack of PRO communication and accountability."

"If DRGs are to be applied nationally, why aren't PROs implemented uniformly."

"Is it fair that the PRO can contract on private, for-profit basis with other insurers? Are they using information from Medicare reviews? Do they shift their best people to the private business?"

"Cash-flow slowed in early 1986 as FI slowed payments. Missed payments for whole month of June."

"Nine month delay in lab reimbursement with change in regulations."

General Criticisms

"Third parties picked up a lot of Medicare-MediCal losses."

"Rising nursing intensity with growing ambulatory surgery."

"PROs, HMOs negotiating away any excess profits."

"Hospital base year a concern as it doesn't include new services."

"Can't shift losses to private sector anymore."

Positive Aspects of PPS

"In early 1985, our projections of costs versus PPS payments showed a significant windfall. Hospital couldn't have paid its bills without PPS."

"PPS system is rational as old cost-based one had no cost or appropriate care incentives."

"Getting out of cost reimbursement fantastic. It was an incentive to spend more money."

"PPS reinforced old philosophy that hospital and medical staffs have to work together."

"PPS finally forced hospital industry to provide a product and a service in a cost accountable fashion."

4.0 PPS AND ALTERNATIVE HEALTH PLANS

4.1 Structure of the Local Industry

In spite of the thirty years of experience California has had with HMOs, it was not until 1982 that the Central Valley had its first alternative health plan. The greater Fresno area was a slow-growing, agricultural community for most of that time, with practically no large employers. Physicians were scarce, and the few in the area formed a close-knit medical community able to discourage HMOs and other competitive arrangements.

Rapid population growth, the influx of several large public and private employers, and significant physician in-migration has disturbed the naturally-occurring equilibrium, resulting in six to nine new health plans in the last five years.* Altogether, they appear to have roughly 30,000 enrollees across the three Central Valley counties of Fresno, King, and
Madera, which is less than five percent of the total population. (Fresno city alone has over 600,000 people.) HMO growth rates have been high, starting from an insignificant base, and some have projected ultimate penetration rates as high as 30 percent. This seems much too high, though, given the number of small employers and perceived unattractiveness of Medicare's at-risk contracting (because of a minimal AAPCC). The area also has numerous PPOs, of which Blue Cross and Blue Shield's is the largest and best known statewide, making the area extremely competitive on the subscriber side.

Interviews were conducted in the two plans that together accounted for about two-thirds of all HMO enrollees--at least as of the fall of 1986. Moreover, every hospital CFO we interviewed was also asked several questions about the role HMOs play in the greater Fresno area and, more specifically, what impact they were having on discounts, utilization, and competition in their own institution. From these interviews, we were able to construct a broader picture of the structure and rivalry among HMOs in the market and develop some opinions as to how PPS and HMOs, together, are affecting hospital behavior and performance.

Before HMOs, the Foundation for Medical Care operated a loose form of IPA with peer utilization review and fee schedules. The new competition led to its dissolution in 1982 and reconstitution as the principal IPA in the community with the backing of the local medical society. At about the same time, several other outside network HMOs began to enter the market, a few negotiating exclusive arrangements with hospitals. The Kaiser Health Plan is the most recent entrant and about the only HMO using a closed panel of salaried physicians. While still small, Kaiser's entry automatically heightens competition among HMOs and portends a serious restructuring of medical care delivery and management

*No two respondents gave the same count of HMOs or who they were, which is an indicator of their small size and the flux in the market.

style if it comes to dominate. In addition, one of the "big three" hospitals dissolved its brief relationship with the oldest Fresno HMO and set up its own HMO owned jointly with its admitting physicians.

None of the HMOs enroll Medicare patients at risk, although all have a few as part of their employer group contracts. Most are IPAs with the notable exception of Kaiser, which is still quite small. As such, these organizations have involved a modicum of practice style changes among physicians, at least until a few become well entrenched.

4.2 HMO Competition

The Fresno HMO market in 1986 is highly fractionated. Two IPAs account for about two-thirds of all enrollees, but a hospital-sponsored HMO is aggressively marketing as well, and now Kaiser has entered as well. None, however, command a significant percentage of the total medical care market, which constrains their negotiating leverage with hospitals. Even the couple of HMOs with exclusive hospital arrangements contribute less than five percent to their hospitals' revenue.

Because HMOs are all so small and new in Fresno, competition among them is wide-open and unfettered by any dominant leader. Establishing a secure membership base remains their first priority. This, coupled with their small size, has discouraged any antagonistic price negotiations with providers. Large numbers of small employers operating in what is still an agriculturally-oriented economy with limited insurance coverage has engendered a wide menu of HMO plans that recognize the market's premium sensitivity. These take the form of a fairly broad benefits package with varying deductible and copay rates. One plan administrator said many small employers wanted to offer their workers some coverage but could afford relatively little, hence the popularity of copays and deductibles. The broad package is based on the traditional scope of services offered by commercial insurers to large employer groups, scaled down financially for small employers.

The generally-held perception of plan respondents is that employees wish to retain the right to choose their own physician, and this is reflected in their IPA orientation. The Kaiser Plan will test this assumption directly, and it will be interesting to see how much employers and employees are willing to pay for this right if significant premium differentials materialize.

It is highly unlikely that all eight or nine HMOs will survive in Fresno in addition to the numerous PPOs that also exist. This fact encourages rapid innovation in product lines, giving subscribers a cafeteria menu to choose from, e.g., full coverage, heavy deductibles and copays, exclusive hospital arrangements, IPAs with large physician panels, and closed-panel physician HMOs practicing in a clinic setting. Until consolidation occurs, the HMOs are too preoccupied with competing with each other to apply much pressure on hospitals.

4.3 HMOs, PPS, and Hospital Contracting

Of the three largest HMOs in Fresno, one has an exclusive contract with the three Community Hospitals of Central California while a second

contracts primarily with their competitor. None at present contract with the county teaching hospital except on a selected services basis. The third HMO contracts with 15 hospitals across three counties and is often the only HMO in outlying rural communities.

Essentially all of the HMOs pay hospitals on a negotiated all-inclusive per diem basis, often with different rates for med/surg, obstetrics, and open heart surgery. Thus, hospitals are at risk for input price inflation and intensity per day but not for longer stays. This affords them protection against long-stay outliers and places that risk on the HMO. While all of the Fresno hospitals accepted negotiated per diems, the discounts were actually quite minor. That they negotiated per diems at all is interesting given the trivial market share of each HMO. Apparently some hospitals felt they were forced into prudent-buyer agreements to maintain their image as quality hospitals. They did not want local residents wondering why a certain HMO had decided not to contract with their local hospital, even if it was the latter's decision not to accept a discounted rate. Another hospital felt HMOs provided a way to protect their markets and physician staffs, so they started their own. Yet another felt it only fair that everyone in the community have access to their institution.

As hospitals enter the third or fourth year of these arrangements, most are seeking to replace per diems with discounted charges. This would effectively shift the risk for intensity increases to the HMO along with the risk for longer stays. It would appear that hospitals are in a fairly good position to accomplish this as HMO volume in any institution is minimal, and either utilization is reasonably good or the hospital has no nearby competitors. With so many HMOs and PPOs, each quite small, hospitals are re-evaluating their initial per diem contracts and making judgments as to which HMOs will likely survive.

HMOs, on the other hand, are under intense premium competiton. Backing into a hospital rate by first determining a competitive premium to subscribers has become common. Hospitals' growing resistence to per diems coupled with heightened premium competiton among HMOs will inevitably squeeze out a few HMOs. This will have the effect of consolidating the market and increasing the bargaining leverage of survivors with hospitals.

4.4 HMOs and PPS Impacts on Their Cost Advantage

Because Fresno is a growing area and practically all hospitals have been financially supported by generous PPS rates, HMOs as a group have not encountered a "hungry" industry needing to fill beds. Furthermore, the area has always experienced very low hospital use rates, one reason for the late arrival of alternative health plans in the first place.

An indirect, nonfinancial benefit to HMOs is reported by one HMO director who felt that local hospitals are more sophisticated in their cost containment and utilization review activities as a result of PPS. HMOs could also leverage new utilization review strategies invoked by the PRO, taking advantage of systems already in place and familiar to the hospital's UR staff. Some concern was voiced that as "the Federal

government ratchets down on PPS payment, hospitals will look for other ways to cost shift, with HMOs a prime target." Until HMOs reach a critical minimum size, which should take several years, they remain more or less at the industry's mercy, rate-wise. This implies even greater reliance upon utilization controls--particularly for admissions. An IPA structure, however, is not well adapted for rigorous UR.

4.5 Contracting with Physicians

Most IPAs pay physicians on a negotiated fee screen with a holdback of 10-35 percent depending on the plan's past performance. The Kaiser plan is the only HMO employing physicians on a salaried basis in their clinic. The medical society's IPA contracts with the majority of local physician while others have somewhat smaller panels. Fees are supposed to be updated annually, but financial difficulties stemming from overutilization have prevented regular adjustments in some plans.

The plans have the usual prior authorization requirements for out-of-plan referrals, selected tests (e.g., ultrasound), and outpatient surgery. A certain reticence exists to sanction physicians for fear that provider participation will fall and jeopardize the attractiveness of their benefits package. Overutilization of hospital services is a continuing problem as a consequence, and the IPAs have reluctantly adopted more stringent review and are imposing modest fines.

4.6 Utilization Review

The IPA plans apply a modified version of the primary physician gatekeeper model to control inpatient use. Instead of delegating responsibility totally to the gatekeeper and use a fee withhold as a carrot for good utilization performance, the larger plans are requiring pre-admission authorization on all but emergency cases. Once admitted, most plans use a combination of delegated and nondelegated UR depending on past performance. MediCal length-of-stay guidelines, which are very stringent, are sometimes employed. Too many retroactive denials of days and services have forced HMOs to adopt more effective concurrent review. This is particularly onerous for small plans that lack the nurses to review cases on a nondelegated basis or to carry out an effective prior authorization program. Scale diseconomies work against small plans which would produce a few failures and necessary consolidation before truly effective UR can be implemented. This would also be an area of real comparative advantage for the Kaiser Plan with its salaried physicians and extensive UR management support, systems, and experience. It also favors the hospital-based HMOs that have a direct financial link with their medical staffs and can concentrate on overutilization in a single institution.

4.7 Medicare Enrollment and Contracting

No Fresno HMOs participate in Medicare at risk contracting as of January 1987. While at least one network HMO has at-risk "test sites" elsewhere in California, the extremely low AAPCC in Fresno county (the

lowest in the state) is a definite barrier. Definite advantages to enrolling Medicare beneficiaries could accrue to HMOs willing to take the risk, including broadening their enrollee base and giving them more negotiating leverage with hospitals as well as spreading the high fixed costs of UR and plan management. The private market also remains a "tough sell," encouraging a second look at the elderly member, but the risk is high, particularly in relation to the low AAPCC.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Site Background

In 1983, there were 919 physicians engaged in patient care in Fresno county. Of those physicians, 134 were in general practice (15%), 207 were in medical specialties (22%), 210 were in surgical specialties (23%), and 184 were in other specialties.* The physician population ratio was equal to 1.8 physicians per 1000 population in 1982.** There were 1,665 inpatient beds in 1982, with 3.1 beds per 1,000 population.**

Physicians in the city of Fresno typically have admitting privileges at all the hospitals in Fresno but actively admit only to one or two hospitals. Physicians in Fresno county, outside of the city of Fresno, generally have admitting privileges at quite a few hospitals and actively utilize several of them. The "county" physicians do not seem to have admitting privileges at Fresno city hospitals. Thus, there seems to be little competition between Fresno city and Fresno county physicians.

Fresno physicians, both city and county, have a very conservative practice style in terms of inpatient admissions and lengths-of-stay. There is a very strong emphasis on performing procedures on an outpatient basis and discharging inpatients early. These practice styles have been in place well before the introduction of PPS and have been attributed in large part to a MediCal pilot project conducted in Fresno country from the inception of the program. Under this pilot project, Fresno county was allowed to administer its own MediCal program but was expected to perform even better than the state-administered program. This led to strong controls on utilization and quality assurance being adopted many years ago in Fresno county. Consequently, Fresno city and county hospitals have had lengths-of-stay below even the California average (which is much lower than the national average) since well before the introduction of PPS.

5.2 Overall Assessment

Although lengths-of-stay were already low, and utilization of outpatient procedures already extensive, there was, nevertheless, a decrease in the lengths-of-stay and an increase in outpatient utilization immediately following the introduction of PPS. One responding physician indicated that most of the reduction in lengths-of-stay came from fewer post-operative days and more outpatient testing and same day surgery.

All the hospitals instituted educational programs for physicians following the introduction of PPS. These programs informed physicians about the nature of the new reimbursement system, the new documentation requirements, the roles of the Peer Review Organization (PRO) and the Fiscal Intermediary (FI). All hospitals report drops in length-of-stay

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*Source: Physician Characteristics and Distribution in the U.S., 1984 Edition, American Medical Association, Chicago, Illinois.

**Source: Area Resource File, 1982.

following the introduction of PPS. In at least one case, sanctions by the PRO on premature discharges reportedly produced a rise in the length-of-stay after its initial fall. The PRO is reported to be less important currently than during the initial period. It is felt that now that hospitals' utilization reviewers and physicians are familiar with PPS and the guidelines of the PRO, sanctions from the PRO are infrequent.

5.3 Length-of-Stay Monitoring

In spite of high Medicare dependency, hospitals appear not to have made any serious efforts to design a practice pattern management strategy in response to PPS. The major reason for this is that they have no financial incentive to do so. Since Fresno county is characterized by low lengths-of-stay and frequent outpatient testing and surgery, there was little need to change practice patterns under PPS. Indeed, with area norms well below the national average, any incentive to change patterns has diminished even further as Fresno hospitals move onto the fully national rate. Furthermore, even though the "county" hospitals are rural in nature, they receive the urban rate because all of Fresno county is designated an urban area. This provides the county hospitals with a windfall gain and insulates them from the pressures facing other rural hospitals under PPS.

As was mentioned earlier, all the hospitals engaged in education programs for their physicians following the introduction of PPS, but this was a one time activity. Utilization review has expanded and intensified. Many of the hospitals now review 100 percent of all cases.

The typical utilization review process works in the following manner. Upon admission, a patient is assigned to a DRG and an expected length-of-stay. This is typically done through the Medical Records department using a commercial computer software package. UR nurses review each patient's chart every day. If the physician's notes are incomplete, or if the patient is nearing expected discharge, they notify the physician. If there is disagreement between the attending physician and utilization reviewer, a physician from the utilization review committee intercedes. According to the respondents, conflicts are always resolved at this point. Formal procedures for resolving conflicts beyond this point exist, as do sanctions for physicians, but no respondent reported any instance of their use.

In keeping with the lack of hospital management strategy for practice patterns, reports on DRGs and utilization are not routinely sent to physicians. In one hospital the respondent indicated that the expected length-of-stay is purposely omitted from patients' charts so physicians will not be influenced by Medicare averages. In addition, only some respondents indicated the presence of formal controls on physician use of ancillaries. Informal peer review or quality assurance committees are controls against serious abuse by physicians of their hospital ancillary service privileges.

5.4 Admission Controls

The biggest change in admitting policies noted by respondents is Medicare's requirement of prior approval by the PRO for some procedures. Again, this impact is relatively small because of the conservative style of Medicine already practiced in the area.

A few physicians admitted that they had social admissions prior to PPS. PPS has led to the discontinuation of this practice. Cases that would have been social admissions in the past are now being referred to home health agencies. While the largest shift in delivering hospital services on an outpatient basis occurred many years ago during the MediCal pilot program, there was an increased shift from inpatient to outpatient delivery of services immediately following PPS. More frequent pre-admission testing on an outpatient basis and more outpatient surgery account for the change. Part of this increase in outpatient surgery is a competitive response to the entry of free-standing centers for outpatient surgery. Respondents feel that part of the trend towards outpatient surgery is due to PPS, but private insurers also are forcing hospitals to make the shift.

Most physicians indicate no change in transfer patterns. The county hospital, however, did indicate that dumping was a problem, and they have started refusing medically unjustified transfers. Another physician indicates that the hospital now has to document transfers more carefully.

Clearly, Fresno hospitals are attempting to handle as many cases on an outpatient basis as is medically advisable. The PRO has played a definite role in this, mainly by requiring prior authorization. The impact of both private insurers and Medicare has caused hospitals to review all admissions more carefully. At present, hospital pre-admission review does not exist in the area, but a number of hospitals are considering implementing it. Consequently, hospitals monitor patients very carefully upon admission but do not typically review the admission itself. The hospitals themselves do not attempt to control "unnecessary" admissions and do not perceive a problem with unnecessary admissions. Physicians, of course, must obtain prior authorization.

5.5 Specialization

Hospitals do seem to be aware of winner and loser DRGs, but this has not been translated into any strategy. Physicians generally have no idea which DRGs are winners and losers, and hospitals have not made concerted attempts to inform them. Admitting patterns have not been affected, and hospitals have not attempted to affect the types of cases admitted.

All the respondents indicate that transfer patterns have not changed materially. The outlying district hospitals transfer patients to the tertiary care facilities in Fresno while city hospitals transfer among themselves for specialized care and send the indigent to the county facility.

5.6 Outcomes

All the respondents indicate that PPS has thus far had no impact on the quality of care, but that it might have detrimental effects if the program is tightened further. If anything, it is felt that quality of care has improved because of more extensive and intensive utilization review and quality assurance.

5.7 Physician Reactions to PPS

Physicians had a number of positive and negative things to say about PPS. Selected quotes are listed below.

"I would hate to be put into a position in which I'm no longer a patient advocate."

"Need to look more at physician practice patterns."

"The PRO is a little reluctant to sanction physicians."

"It's made us all aware that you can't have everything for everybody."

"Don't want to make it so tight that they [physicians] have to think about cutting corners about care they should be providing."

"It hasn't prevented me from practicing the kind of medicine I feel I should practice."

"PPS has really made some inroads into establishing cost containment."

"This has stimulated places to develop more than one standard of care."

"I don't know whether DRGs are going to save the government money."

"I don't know that it's done a whole lot to medical practice."

"Somehow or other we have to get the cost of this under control."

"Must make allowance for teaching institutions and unfavorable mixes, or divide DRGs more fairly."

"I don't find it hard to live with at all."

"PPS is a desperate attempt to deal with a bad situation."

"Made physicians more aware of aggressive inpatient treatment and post-hospital care."

"It's probably been long overdue."

"I suppose it's hard on the patient."

"The previous system was stupid, but it's been replaced by another stupid idea."

"Some economic decisions will be bad medical practice. If hospital is hanging on by its fingernails financially, some terrible things could happen."

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

6.1 Industry Structure

There are 77 licensed nursing homes in what the state considers the Fresno region; 57 are Medicare-certified skilled nursing facilities (SNFs), 73 are Medicaid-certified facilities. There is, by all accounts, a shortage of all types of nursing home beds in the area, whether skilled or intermediate, private pay or publicly supported. This shortage permits nursing homes to be selective about the patients they accept, with the result that hospitals must make special efforts to place certain types of patients.

Medicare is a very small part of the business of nursing homes in the Fresno area. The facilities visited, while Medicare-certified, report having only two or three Medicare patients at any time. Thus patients needing nursing home care must pay out of pocket for that care unless they are poor and qualify for Medicaid.

Of 28 licensed home health agencies in the Fresno area, only five are Medicare-certified. Home health services are provided by proprietary and nonprofit agencies; most of the latter are connected with hospitals. There is no Visiting Nurse Association, the most traditional voluntary agency type, in Fresno. Several home health agencies, mostly parts of national chains, opened during the early 1980s and then closed. Reasons for these closings are unclear, though aggressive hospital entry into home care may have been a factor.

Hospitals have developed discharge planning activities to varying degrees; some have retained the traditional social services model, while others have moved toward other models, including a nursing model, and a combined utilization review-discharge planning model. Hospitals that have been the most aggressive seem to be adopting the nurse-dominated model; most are using home health agency nurses to help them in discharge planning.

A major reason for this shift is the increased need for clinical assessments and planning for high tech or complex care in the home. In the past, a great deal of discharge planning consisted of patient and family counseling, securing a nursing home bed, and obtaining Medicaid coverage for the patient. The shift toward earlier discharges, and changing practices and technologies of home care, have resulted in a large number of patients being discharged with continuing medical needs. The ability to perform clinical assessments and determine the amounts and types of treatments needed is now an essential ingredient in discharge planning.

Even in hospitals where there seems to be an active discharge planning staff, there is a feeling on the part of that staff that they are still not taken very seriously by the administration. The potential of the unit for helping patients to get out earlier, thus saving money for the hospitals, does not yet seem to be fully recognized. Home health agencies generally observe that discharge planning has not yet been organized as efficiently as it might be.

Problems of premature discharge and people not receiving needed care are not perceived as widespread problems, though discharge planners and post-hospital care providers all agree that they do happen. Physician tendencies to ignore the importance of discharge planning or home care are cited as problems, along with the tendency of some to occasionally send a person home too soon in the recovery period. Readmissions to the hospital occur, though no one knows how frequently. Home health agencies report receiving calls for assistance from patients and families soon after discharge. Some interviewers feel that patient and family misperceptions of premature discharge result from misunderstanding of medical practice or the lack of funding for nursing home care.

6.2. Hospital Admissions and Discharges

Hospitals in Fresno have historically had short lengths of stay, as is typical of the West Coast. Still, lengths of stay and admissions have dropped even further recently in most hospitals. Inevitably, patients are being discharged earlier in the recuperative process, and the types of patients being admitted are more carefully screened. It is extremely difficult to document the kinds of patients not being admitted and there is not much discussion of them. Most people, however, have opinions about the kinds of patients being discharged sooner and the problems created by earlier discharges. There is little documentation or consensus about the extent of the problem, or how many needy patients are not receiving care.

Premature discharges and patients "falling through the cracks," or not receiving needed post-hospital care, are widely perceived as happening, but not very often. Reasons for early discharge and failure to receive care are varied. Physicians are sometimes criticized for discharging too early because of pressure from hospital administration. One hospital reportedly puts pressure on its admitting staff, and patients are told that their "DRG is up." Physicians also are said to make inadequate use of discharge planning services, either ignoring them or requesting them at the last minute. Discharge planners relate stories of being stopped in the halls with requests for immediate arrangement of home care for a patient being discharged. Other physicians are reported to resent the intrusion. The picture is mixed, however, and there is a general feeling that physicians are learning about the value of home health care and of discharge planning.

It appears that most skilled care needs in the home can be met by Medicare services if they are ordered by the physician. Often-cited exceptions are respirator care and home antibiotics (classed as drugs), which are not paid for by Medicare. The problem of "falling through the cracks" is more often a failure to order services and lack of funding sources for the immediate post-hospital personal care and home support services.

There is not full agreement about whether a patient has been discharged prematurely. Some examples cited were qualified as "this has always happened," or "a patient with a severe behavioral disorder cannot

always be prevented from harming himself" (by pulling out a catheter, for example). Other instances of problems are patients sent home with catheters, or before they have been ambulated, or with complex problems, or without patient or family being taught how to provide care.

Repeated admissions and readmissions were cited as problems that sometimes occur due to discharging a patient who is not stabilized. Home health agencies report seeing patients coming home in this condition and later being readmitted to the hospital.

Overall, a major shift in the kinds of care provided in various settings has occurred. Home health care is the focus of most of the change as more complex and more high-tech cases are now being cared for at home. This seems to be the result of a number of factors. First, medical practices have been changing over the past few years, and the view of what can be done in the home has expanded greatly. Along with this has come better technologies for home care, allowing more high-tech care in the home. A third factor has been the hospitals' incentives to discharge patients sooner; this is a long-standing trend that has accelerated in the past few years. Fourth, nursing homes are no longer viewed as the only or the best focus of post-hospital care. Finally, nursing homes frequently turn down patients who are subsequently accepted for home health care.

6.3 Hospital Discharge Planning

There is substantial variation across hospitals in the organization, staffing, and functions of discharge planning. This appears to be true around the nation, and is no less so in Fresno. Discharge planning roles depend on overall hospital aggressiveness in seeking early discharges, moderated by the traditional arrangements, training, and personalities of those who run the units.

Discharge planning traditionally is located in the social services departments of hospitals and is staffed by social workers. In some hospitals, however, the function is located in the nursing department, or the responsibility is shared between nursing and social services. In the latter case, nurses arrange for home health care and social service staff locate nursing home beds along with their other functions. In one hospital the discharge planning activity, along with utilization review, reports to finance. In another, it is a free-standing function.

There is some interest in combining utilization review and discharge planning, permitting an early point for discharge planning intervention and better continuity of care. It appears to be working well in two of the hospitals visited, and is being considered by another. One hospital assigns a utilization review/discharge planning nurse to each floor to provide continuity of coverage. However, even here the home health agency nurses arrange for home health and durable medical equipment.

The discharge planning function seems to be utilizing the nursing staff more, for a number of reasons. The increased medical and monitoring needs of patients being discharged earlier, the increased use of home health services, and the need to communicate complicated

post-discharge procedures call for the nurse to assess needs and organize care. In addition, nurses may be able to communicate with physicians better concerning the need for post-hospital care and to educate them about discharge planning, as well. Social workers may be less aggressive in approaching physicians, initiating planning, or cautioning them about care for certain patients.

Discharge planning in most hospitals is augmented by home health nurses. The hospital arranges with a particular agency, usually one it owns or has some contractual relationship with, to have a nurse come to the hospital to see patients, talk to their families and physicians, assess needs, and develop a plan of treatment for home care. Depending on the size of the hospital, one or more full-time nurses work on-site, or a part-time arrangement is made. Generally hospital nurses are not well versed in the possibilities and limitations of care in the home, so this arrangement lends the needed perspective.

Most hospitals use some screens to target vulnerable patients at or shortly after admission. The screens commonly include the following patient characteristics:

- Very old age
- Stroke
- Hip fractures and replacements
- Admission from a nursing home
- Living alone.

Although these screens exist, their application and timing are unclear, particularly where physicians must initiate planning. Most discharge planners say they participate in case conferences or at least review records. The case conferences are multidisciplinary, often including physical therapy, home health, nursing, dietary, pharmacy, social work and discharge planning. The conferences are intended to identify all possible problems and determine how to handle them upon discharge from the hospital.

If home health services are determined to be appropriate, a plan of care is developed, presumably with physician involvement. Durable medical equipment (DME) is usually ordered by the home health nurse, although in one hospital it is ordered by the discharge planner. Complex cases for DME are handled by nurses and others by social services.

Home health care is increasingly recommended by discharge planning for many reasons such as a changing awareness by physicians and discharge planners of its efficacy and a general shortage of nursing home beds. Also mentioned is the earlier discharge of patients still in need of care.

Most hospitals have had social service departments for a long time, though little home care may have been recommended heretofore. The shift toward nursing involvement, even dominance, and alternative organizational arrangements, is quite new and appears to have been spurred by the Medicare Prospective Payment System (PPS). One discharge planner, hired two and a half years ago, said her hospital previously had

no discharge function. A second said her hospital had completely reorganized and re-staffed its discharge planning activity. Even in these hospitals, however, staff feel they are not taken very seriously by administration, though they think this attitude is changing as administrators begin to see how effective discharge planning can be.

Problems of planning for discharged patients in the Fresno area center on the shortage of nursing home beds. Not only are beds generally scarce, but the shortage permits facilities to be selective about the patients they accept. Thus a group of "hard to place" patients must remain in the hospital waiting for beds. Nursing homes by all accounts, including their own, have been adamant about not taking patients in these categories:

- Intravenous feeding, medication
- Tube feedings
- Advanced decubitus ulcers
- Tracheotomies and frequent suctioning
- Behavior problems.

Nursing homes say these patients require more intensive care than they are equipped to provide.

Another problem group is respirator patients for whom Medicare does not pay. Although they can be cared for at home, the lack of payment prevents this, except for MediCal eligible patients.

6.4 Home Health Agencies

The Fresno area has seen a period of growth in the size and number of home health agencies, followed by a period of consolidation. Some agencies, mostly for-profit chain organizations, closed. Hospitals began home health agencies to provide their patients with a reliable source of home care. One home health agency is owned by a holding company that owns several hospitals in the area; staff from this agency supplement the hospitals' discharge planning activities as well as providing home health care. Another hospital-based agency serves primarily patients from that hospital, while yet another hospital has a formal contract with a home health agency. Finally, another agency is part of a group of clinics organized as a non-profit corporation.

There is not much competition among the home health agencies, in part because they are few in number (five) and because most have formal arrangements with hospitals and enjoy a captured market. As noted, many small, free-standing HHAs have already gone out of business, leaving a few stronger ones that feel a sense of alliance among themselves. This is fostered by a perceived need to defend against fiscal intermediary policies that hurt the agencies as a group.

There is some sense of impending competition due to the expected entry of HMOs into the Fresno market. Currently there is almost no HMO home health activity, although Kaiser is a new entrant and is expected to provide home health services to its members.

Agencies with formal hospital contacts, either proprietary or contractual, appear to be growing rapidly. One agency reported that its caseload has doubled in each of the past three years. A smaller, independent agency has not gained substantially from earlier discharge practices by hospitals.

6.4.1 Adaptations

Home health agencies have made many adaptations in the past three years to accommodate growing demand and to provide more complex and high-tech care. Not only has new staff had to be added, but higher clinical skills are needed now. Agencies are more insistent on hiring nurses with good assessment skills and training in intravenous (IV) care and total parenteral nutrition (TPN). Cardiac Pulmonary Rescusitation (CPR) is also considered essential, since they see a lot of cardiac patients who are not stable after discharge. There has also been an increase in cancer patients and consequent IVs for chemotherapy. One home health agency has a contract with a "High Tech" (IV, TPN) group to train the home health agency nurses, service equipment and provide backup relief.

The rapid growth in the home health industry over the past five years is attributed to changing medical practices, different conceptions of home care, and earlier hospital discharges. Agencies think that the types of care requested have stabilized, but that the numbers of home care patients will continue to grow. This growth may also slow down in the next year or so as hospitals exhaust opportunities for earlier discharges to home care.

6.4.2 Patient Care Problems

Home health agency staff all report having seen some instances of premature discharges, resulting in problems for families or readmissions to hospitals. They mention the "revolving door" phenomenon of heart failure patients and those with chronic obstructive pulmonary disease. Lack of understanding or compliance with medication in the absence of home health monitoring are cited as contributing to readmissions. The agencies believe that substantial physician education is needed before they will understand and prescribe home health services for their patients. HHA staff seconded the discharge planners' concern that physicians pay insufficient attention to post-hospital care needs of their patients.

Most skilled nursing and home health therapies following hospitalization are covered by Medicare, exceptions being respirator care and IV antibiotics. Within some limitations, then, skilled services, if ordered by the physician, are provided. Agencies believe that the fiscal intermediary denies needed visits, but their evidence is not clear.

It is certain, however, that no funding is available for the non-skilled services needed following hospitalization. Many patients are still weak, or are too frail to provide self-care, and either live alone or their spouses (or others) who are not physically or mentally capable

of providing the care. A great many patients cannot afford to pay for homemaker or personal care services and are not sufficiently poor to qualify for MediCal.

6.4.3 Administrative Problems

Home health agencies voice several concerns about the administration of the Medicare home health benefit by HCFA and the fiscal intermediary. There is a pervasive belief that the benefit is too limited, and that HCFA wants to tighten it even further. Paperwork burdens are also cited, mainly the new plan of treatment forms and the need to extensively document care. One agency stated that its nurses spent as much time on paperwork as on visiting patients. Another agency said its costs were increased drastically by the "paperwork requirements." According to that agency a private duty nurse costs under $25 per hour, against the Medicare nursing visit cost of $75 (the average visit is less than two hours).

The major criticisms focus on the fiscal intermediary's actions. The rate of home health agency claims denials in California has jumped from 3.9 percent to 14.2 percent since the HCFA plan of treatment form (485) was instituted.* As a result of this increase, nearly three-quarters of all the California agencies have had their waiver of liability removed. This in turn means an increase in the denial rates, since projected ineligible claims are now not paid.

The home health agencies also believe that the fiscal intermediary makes arbitrary decisions and just as arbitrarily reverses them, often without notifying providers. There is a perception that the FI makes "arbitrary" decisions that are not consistent with the law or the regulations. Problems with therapy services are cited, as are denials of home health aide (personal care) services if there is a (state-supported) "chore" worker coming into the home.

Finally, the respondents believe that the FI denies care on the ground that it is not "medically necessary," but does not provide an explanation of their decisions. Providers must spend large amounts of time documenting and filling out forms and are unsure of what will be covered. The FI denies most of the statements by the providers.

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*The reasons for this are numerous. The fiscal intermediary in California denies claims that are not properly completed, and introduction of a new form inevitably causes recording errors. Further, HCFA's system of rating FI efficiency rewards larger-dollar claims denials. Since the FI no longer reviews hospital claims, the large dollar claims are not available to offset the overall dollar volume of HHAs. HCFA has not made adjustments to reflect the difference in provider mix. FIs now must increase denial rates of other providers significantly in order to make their scores.

6.5 Nursing Homes

Nursing homes play an extremely small role in providing Medicare-covered services, though they obviously serve Medicare enrollees. The nursing homes visited report only one or two patients on Medicare at any given time; these facilities have well over 100 beds each. As in other states, they have not seen a major change in their roles since PPS. This is largely due to the chronic shortage of nursing home beds and firm, self-imposed control on the kinds of patients accepted from hospitals.

Hospital discharge planners and nursing home administrators appear to play almost adversarial roles, as hospitals try to locate beds for difficult or heavy-care patients, while nursing homes refuse to take most of them. Nursing home administrators appear unwilling to take discharge planner's word for the actual condition of the patient and will often visit the patient prior to discharge from the hospital.

Both the profit and nonprofit nursing homes say their patients are in general sicker than they used to be on entry into the nursing home. This is in part due to the fact that old people are kept at home longer now and are placed in the nursing home only when other alternatives are exhausted. Patients are also sicker when they are discharged from the hospital.

Facilities in California, being in demand, are in a position to select their patients carefully. Thus they try to avoid patients who create serious problems or who need heavier care than the facility is staffed to provide, e.g., terminal illness, intravenous tubes, bad decubitus ulcers, and behavioral problems.

The primary conditions for which Medicare makes payments for SNF nursing home patients are hip fractures and hip replacements. Care for these consists largely of physical therapy and is of short duration. Nursing facilities appear to have no confidence that the fiscal intermediary will authorize payment for any other conditions. Staff has said that even the hip fracture patients are coming out of hospitals sicker because of shorter lengths of stay, which are sometimes as short as four days after surgery.

7.0 PPS PROGRAM OPERATIONS

7.1 Peer Review Organization

7.1.1 Administration and Organization

California Medical Review Inc. (CMRI) was awarded the first PRO contract in California and recently signed a second contract with HCFA. CMRI was not a pre-existing organization, but was formed specifically to compete for the PRO contract, winning over the old Professional Standards Review Organization (PSRO).

The California PRO is one of the largest in the nation, and its organization reflects this in its division of functions. For example, utilization and quality reviews are managed by separate staffs, while in smaller PROs they may be the same. Their data collection and analysis capacity is large and sophisticated. One result is that CMRI was the first to publish provider-specific statistics on such things as mortality rates by specific hospitals. With this capacity for statewide, systematic review and database development, CMRI is able to identify aberrant practice patterns as well as individual cases.

7.1.2 Functions

On-site record reviews have been the major method of medical review by PROs. However, with the tighter budget in the new contract, CMRI plans to centralize at least some record reviews by having hospitals reproduce and send records to them instead of sending nurse reviewers out on site. Currently, CMRI has 700 practicing physicians on retainer to assist with the review process.

Initial reviews are performed by nurses, who flag questionable claims for review by one of the physicians, who then serve as secondary reviewers. The computerization of the results of initial record reviews has enabled CMRI to flag claims for secondary review. This flag occurs after the initial review by the nurses, who use their own set of screens. Nurses may only approve care, but may not deny services. Thus all claims that are identified by the nurse or the computer screens are sent to physicians for further review. Two levels of physician review are triggered in turn: generalist reviews and, if necessary, reviews by specialists. About ten percent of records undergo this off-site review.

Record review samples are drawn the claims tapes received daily from the Fiscal Intermediary and sent to the hospital for record retrieval. Higher percentages of records are reviewed for readmissions within 15 days, and for transfers among hospitals. CMRI believes the review of transfers has been effective in spite of the lack of HCFA guidelines. They also review, as required, 50 percent of outliers, a ratio they consider unnecessarily high.

In addition to the hospital reviews, CMRI is doing HMO utilization reviews for all nonadmitted cases. They believe there should be other reviews as well, for other providers, to achieve a continuum of review for nonhospital care. California is one of the PROs eligible to compete for new contracts for HMO quality reviews.

7.1.3 Relations with Government and Providers

Super-PRO ratings of CMRI are within the national norms; CMRI's denial rate is five percent. The DRG agreement rate is "poor," but getting better, and for quality CMRI has a less than one percent disagreement rate. The PRO believes that HCFA thinks well of them, and they say they have received no HCFA pressure to increase denial rates. CMRI seems to think the new contract is a substantive improvement, in spite of the tighter budget allocations, as it focuses on more relevant areas of utilization and quality.

The responses of providers to CMRI activity have been substantial, if not always calm. CMRI believes that hospitals and physicians have responded in major ways to their presence, with large changes in the number of admissions, length of stay, ambulatory surgery, and levels of care. The staff believes quite firmly that the changes are the result of PRO activity far more than the new Medicare Prospective Payment System (PPS). This view is also held by other PROs and providers in other states.

CMRI has taken an aggressive position in reviewing quality and recommending sanctions; it leads the nation in numbers of sanctions recommended. Indeed, the first hospital to lose its Medicare certification is in California. This activity, however, has placed CMRI in an adversarial position with California's physicians, particularly with the medical societies. Hospitals, including the California Hospital Association, have, according to CMRI, been largely supportive. This is not surprising since CMRI acts as a control on physician practice patterns in a way the hospitals cannot. CMRI has made serious efforts at physician education in order to alleviate problems and misunderstandings.

CMRI has made it a policy to publish the data they collect, so the public can assess individual hospitals and physicians. This places additional pressure on providers; in addition to worrying about claims denials they must be concerned with their public image. CMRI staff believe they are perceived as a threat to organized medicine and are concerned that their findings will result in actions against physicians, hospitals, and ultimately in litigation against CMRI. It is perhaps out of concern about being too aggressive that CMRI has performed no reviews outside the objectives required by HCFA.

Sanctions may be granted against providers by the Inspector General of HHS if the PRO recommends them. CMRI has initiated 96 sanction actions. Of those initiated 18 actually were recommended and 13 were approved.

7.1.4 Review Process

Many steps occur in the review process before it culminates in the sanction process described above. As mentioned earlier, CMRI relies on a system of computer screens, nurse reviews, and physician review and consultation. Regional Medical Directors employed full-time by CMRI review routine cases. If there is a single problem with a provider

(i.e., one serious case), it is handled at the regional level. If a pattern is identified, the case is forwarded to the central office of CMRI for the next steps, including initiation of sanctions.

Lesser actions regarding quality include sending letters to providers when problems are identified. As of October 1986, 550 letters for quality problems had been sent to physicians, who are then asked to respond. CMRI follows up on nonresponses and flags for special scrutiny those physicians with more than three problem cases. This is a point at which physician education activities might profitably occur.

In the quality review process, however, there is no initial contact with the provider except for the letter; under some circumstances the PRO may talk to hospital quality assurance staff. Quality issues are considered so sensitive that arms-length relations must be maintained between the physician reviewed and the physician reviewing.

A shift in emphasis is occurring from reviewing single cases to identifying physicians and hospitals with repeated problems. The PRO attempts corrective action before initiating sanction actions, and has taken aggressive actions with some hospitals. They require some hospitals to have all of their records reviewed by an outside entity (not the PRO).

In the review of utilization there is much more contact with providers, as this is a somewhat less sensitive area than quality. In fact, HCFA initially instructed the PRO to telephone the physician prior to issuing the claim denial. Physicians on both sides apparently found this conversation awkward, even though it was intended only as a way to allow the provider to supply more information in support of his claim. Now, however, this interchange may be carried on in writing, and this method is preferred by all involved.

Claims denials based on utilization have apparently had their effect on medical practice; among the most effective review targets were cataracts (the number one procedure in California) and inguinal hernias, for which significant reductions were realized. CMRI considers several other procedures that are targeted by HCFA to be ineffective review targets. HCFA mandates preadmission review of five procedures: total hip replacement, cholecystectomy, transurethral resection of the prostate, coronary bypass, and pacemakers. CMRI maintains that very few claims for necessity of procedures are denied, so that such reviews are inefficient.

CMRI uses its large database to undertake a variety of special studies. It has made a study of inappropriate discharges by examining readmissions within 20 days and deaths without readmissions within the period. It is one of seven PROs designated by HCFA to study premature discharges. This study looks at stability at discharge and readmissions within 20 days of "premature" discharges. Heart surgery was involved in a specialty study, and specialty hospitals have also been examined.

The PRO has studied readmissions within 7 days, but lacked the information to identify premature discharges. It has also looked at swing beds in California; problems were identified in that the use of swing beds permits a big drop in hospital length of stay in the acute care episode. The patient continues to receive the same care, in the same bed, but not at a cost to Medicare. The swing bed is now paid for by the patient or by MediCal.

The PRO has also identified some instances where pre-operation and post-operation stays are separated from the acute care episode and charged to the beneficiary. It is felt that Medicare beneficiaries do not understand their benefits or their rights and do not understand that they may appeal to the PRO. CMRI believes also that in the current cost-cutting atmosphere hospitals are concerned with maintaining their bottom lines, and occasionally misapply "average length of stay" as a ceiling in determining patient stays.

7.2 Fiscal Intermediary

7.2.1 Administration

Blue Cross of California is the Fiscal Intermediary (FI) for the Medicare program, and is the Regional Home Health Agency Intermediary for the states in Region IX. Blue Cross of California is the nation's largest Medicare Fiscal Intermediary, as it serves 1,100 providers, including about 400 hospitals. In one month it processes 338,000 claims. Sixty-five percent of their receipts come from outpatient services; 17 percent from hospitals; 7 percent from home health; and one percent from skilled nursing facilities (SNF). As The Regional Home Health Intermediary, Blue Cross of California processes claims for freestanding home health agencies in the several states.

Blue Cross provides detailed manuals to hospitals to inform them about Medicare's Prospective Payment System (PPS) and its implementation. The manuals, which are periodically updated, contain instructions to hospitals on how to complete their claims, how Blue Cross computes their rates, outlier information, and the like. When hospitals receive their rates they are given separate figures for the hospital specific and other portions of the rates.

Blue Cross also uses a system of Medicare Bulletins to inform hospitals' Chief Executive Officers of all changes. Every time there is a policy or payment change, the hospital is informed, and if rates change Blue Cross computes the new rate and notified the hospital.

Blue Cross also holds briefings for hospital staff, but feels the information doesn't always get transmitted to the right people; many hospital administrative staffs do not have a strong grasp of the complexities of PPS and rate components and calculation. The Chief Financial Officers are the ones who, in the FI's opinion, should attend the briefings; in reality it is usually the billing staff who attend. Blue Cross states that substantial re-education of hospitals is necessary before they understand new payment systems.

Since the inception of the peer review system, Blue Cross has met regularly with the Peer Review Organization (PRO), and according to both parties, relations are good, as they work on claims review processes and problems. Claims tapes are transmitted to the PRO on a daily basis for expeditious reviews.

7.2.2 PIP and CPEP

The elimination of the Periodic Interim Payment (PIP) systems for hospitals is expected to create problems for Blue Cross, as it will result in an "excessively" complicated payment system. Whereas now payment is made only by DRG, HCFA will allow split billing to assure timely payment. This will permit hospitals to bill in 30-day segments, and will require different treatment of outliers. This is expected to result in substantially more work in claims processing.

Blue Cross believes that the Contractor Performance Evaluation Program (CPEP) scoring system should be revised in the wake of the changes wrought by PPS. The cost to savings ratio continues to be the same, even though the hospital claims review activities have been shifted to the PROS. Hospital claims reviews and denials produce larger relative savings than do outpatient and home health claims review. Since Blue Cross is still being held to the former yardstick, claims denials will have to increase in numbers if they are to continue to meet the CPEP dollar savings requirements.

One result of this pinch is that many providers, particularly home health agencies, have lost their waiver of liability. The intermediary may subsequently count as denials all claims heretofore paid under the waiver provision, thus increasing the cost-to-savings ratio. HCFA does not appear likely to adjust the fiscal intermediaries' performance factors for the loss of the hospital claims review activity, however.

7.2.3 Review Activities

As with all fiscal intermediaries, there are two levels of claims review: first to check patient eligibility and claim completeness; and second to review medical necessity and appropriateness of services. For hospital claims Blue Cross has over time installed computer terminals in most of the hospitals so they can enter claims "on line". This capacity mitigates the effect of no longer having notices of Medicare eligibility. The on-line system allows hospitals to query Blue Cross on the availability of lifetime reserve days and other eligibility questions. California appears to be one of the only FIs providing this service. Hospital-based skilled nursing facilities and outpatient services also have claims submitted in this manner.

Most freestanding SNFs and home health agencies submit claims in hard copy, and Blue Cross staff then key in the claims. They are returned if there is no Medicare (HIC) number, or if other parts of the claim form are missing information. This is the only reason for returning claims to the providers, except for incorrect or invalid codes.

Blue Cross responds to PRO approval or denial of hospital claims. If a claim is denied, Blue Cross adjusts the claim and subtracts the payment. Medical review is done by Blue Cross for all services except acute care hospitals, which are now the PRO's responsibility. Blue Cross performs medical reviews for home health agencies (HHAs) SNFs, and part B inpatient and outpatient bills. Health Maintenance Organizations (HMOs) are also reviewed by Blue Cross.

Medical review staff consists of registered nurse auditors, who perform the first manual review for claims that either fall through screens or for which review is required. Consultants are used as necessary for secondary reviews: physical, speech and occupational therapists, respiratory therapists and physicians are all used.

Proportions of claims to be reviewed for medical necessity and appropriateness vary by provider type. Thirty percent of freestanding SNF claims, and 100 percent of hospital-based SNF claims are reviewed. HCFA requires home health claims review of all initial certifications and recertifications (every 60 days), which results in reviews of well over half of all HHA claims.

A major source of controversy in home health reviews has been the new plan of treatment (known as forms 485 and 486). HHAs complain that many are denied simply because information is missing. Blue Cross says this is true; they deny when forms are not properly completed, rather than returning them for clarification. They assert that it is the only way to "get the attention" of the HHAs and force them to complete forms properly.

The denial rate for SNF claims has risen, according to SNF personnel, and the rate for HHA claims denials has risen dramatically, according to all parties. Most home health agencies have lost their waiver of liability due to the increase in claims denials; 75 percent of HHAs are now off waiver. Blue Cross has said they receive signs of full approval of this practice from HCFA. Currently, 14.2 percent of HHA claims are denied, a rate far above the national average of about 3.7 percent, and up, in just one year, from 3.9 percent in California.

Widespread HHA complaints were that claims are denied on grounds that the care is "not medically necessary," but without explanation. Blue Cross does send a form to the agencies with space for recording the reasons for denial in some detail. However, it is not clear that details are always written down, as it appears possible to simply write "not medically necessary."

Grounds for medical necessity denials for home health appear to range, in the eyes of Blue Cross, from no need for care to a few unneeded visits at the end of an episode, to the patient being too sick to be cared for at home. For SNFs, denials appear to focus on custodial care or too infrequent a need for skilled care. About one-third of SNF claims are denied. SNF care that appears to be considered covered includes skilled nursing care seven days a week, IV tubes, dressing changes several times a day, hip fractures and replacements (physical therapy), and short-term nasogastric tubes, intramuscular medications, and some other time-limited conditions.

Outpatient clinic medical reviews focus on inappropriate outpatient procedures, such as first time pacemaker implantation, cholecystectomies, and mastectomies with stays of under 24 hours, which has apparently occurred. Medical records are requested in these cases; some are sent to the PRO and to HCFA for follow-up action.

Skilled nursing facilities and home health agencies are concerned with the large numbers of claims being denied, inconsistency in claims review standards and changing definitions and medical review criteria.

SNF patients covered by Medicare have dwindled to practical nonexistence. HHAs still provide substantial Medicare services, but they are increasingly at risk for denied services.

The fiscal intermediary says that part of the problem is the providers' (particularly HHAs) lack of understanding of the Medicare benefit, inadequate documentation of care, and over-provision of services. Blue Cross has said that they are denying claims in part to force the providers to improve these things. HHAs have said that a few visits at the end of an episode are routinely denied, an act they consider arbitrary. Blue Cross says the providers engage in "creative writing" to get more visits covered. The FI does validation audits in home health agencies; nurses compare the medical records to the plans of care (485 and 486) to assess the congruence between patient conditions and the services prescribed.

Definitional problems occur most often for home health care. The definition of skilled care is problematic, in part because the HCFA manuals do not define it, so it is left to clinical judgment. This, of course, varies by individuals, producing inconsistent application of criteria. Daily care is also a problem, as it may be defined as seven or five days per week, and its expected duration may be a factor. Finally, the criteria for assessing whether a patient is homebound present problems for providers. Blue Cross believes that HCFA has been very tough in this area and has encouraged the FI to tighten up.

7.2.4 Relations with HCFA

Blue Cross feels that many of its actions that have been criticized by providers are really the result of HCFA pressures, both direct and indirect. The slow-down of claims payment, and the increased number of claims denials are said to be the direct effects of HCFA instructions and the CPEP score problem. Other signals are given, but more vaguely. In addition, the FI often has difficulty obtaining clarifications of HCFA intent and policy. An example given was Blue Cross' attempt to ascertain whether HCFA intended to cover acute, long term continuous care in the home. Medicare was thought to be a time-limited benefit, but with other system changes, such as PPS, more patients needing skilled care need it for a long period. Blue Cross says it has been unable to obtain responses to this and other inquiries.

Another problem, discussed earlier, is the the fact that HCFA has not changed the productivity scores to accommodate the loss of hospital claims. From the FI's viewpoint, HCFA does not intend to adjust the criteria, thus forcing the FI to increase claims denials for nursing homes, home health agencies and clinics.

Cash flow from HCFA is cited as another problem. It is uneven through the year, depending on Washington's policy and budget priorities. HCFA reportedly withheld funds from all the FIs over the year, then gave a sudden large distribution.

This unpredictability is said to make management difficult. The FI is told to tighten, then loosen, claims review and payment. They

eliminate workers and then must rehire them. As a partial result, Blue Cross has sought economies by reducing home and provider visits for quality reviews.

Blue Cross says that many new policies and changes increase workload. The new fast payment cycle will create problems for FIs. The elimination of Periodic Interim Payments (PIP) will provoke provider complaints and require more manual adjustments. Blue Cross audit staff say that PPS has increased paperwork because more information, not less, must be collected. They are still auditing cost reports and expect a heavier workload when capital costs are phased in to the hospital payment system. Further workload increases are expected as skilled nursing facilities move to the prospective payment system. HCFA policies have not been specific on many of these areas, thus creating uncertainty for the FI.

The FI says that the need to adjust hospital claims has increased under PPS partly from incorrect coding of DRGs. The new HCFA policy of permitting hospitals to submit partial bills will further increase claims processing costs and will require more manual processing. While costs are increasing, Blue Cross says that its contract budget is being reduced from year to year, so that they are not sure they will be able to accommodate greater claims processing costs at the same time funds are being reduced.

7.2.5 Beneficiary Problems

From the perspective of the fiscal intermediary staff, beneficiaries are facing increasing problems of early discharge from hospitals and higher out-of-pocket costs. Patients are going home much sicker, as evidenced by the changes in level of care being provided. Increased "high-tech" care is seen in claims, as well as more daily care and longer stays needing acute (skilled) care. They see home care changing tremendously, replacing part of the hospital episode.

This trend has created some problems in that medical review staff see more home health claims for patients they consider to be too ill to be cared for at home. In other words, they may have been discharged prematurely from hospitals. Examples of patients considered too sick to be at home were patients with bilateral chest tubes, some cases that normally are in Intensive Care Units (dobutamine drips), third day post-operative mastectomy with drains, and third day post-operative hip fracture with other serious conditions.

In addition to the increase in high-tech care such as IVs, the FI has seen a growth in hospice care (this is one service for which they accept most claims). This case severity increase does not appear to have affected nursing homes in the area as much as home care.

These trends and problems cited by the fiscal intermediary corroborate statements by home health agency and nursing facility staff. There was a common impression of a small but significant incidence of premature hospital discharges, with the result that patients are sent home with far greater needs for both skilled and unskilled care than in the past.

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